NURSES' PERCEPTION OF THEIR COMPETENCIES IN THE PROVISION OF PSYCHIATRIC CARE: A CASE OF LOITOKITOK SUB-COUNTY HOSPITAL

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DECLARATION

I hereby declare that this thesis is my original work and has not been presented before for a degree in the same or different university for academic or any other purpose.

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Supervisors' Approval

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DEDICATION

This thesis is dedicated to my beloved husband David Nyotu, my children and grandchildren.

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ABSTRACT

Ideally, psychiatric services are offered by nurses specialized in this area. However, due to the current acute shortage of these experts, deployment of general nurses in caring for clients with mental ailments has become inevitable. Competency in service delivery is either real or perceived. Nurses' self-perceptions on their know-how to offer services influences their confidence; and ultimately the quality of patient care. However, there is shortage of literature on nurses' perceived competencies in psychiatric care in Kenya; and particularly in Loitoktok Sub-County Referral Hospital. This is concerning especially since shortage of specialized psychiatric nurses has made it inevitable to deploy general nurses to provide care for the mentally ill. Therefore, the study aim was to assess nurses' self-evaluation of their competencies in the care of psychiatric patients at Loitokitok Sub County Hospital. The specific research objectives that guided this enquiry were: to assess nurses' perception on psychiatric assessment in the provision of psychiatric care; to establish nurses' perception in application of therapeutic Communication in the provision of psychiatric care; to determine nurses' perception in ability to provide the needed interventions in the psychiatric care; and to determine whether there is an association between nurses' length of professional experience and perception of their competencies to provide psychiatric nursing care. A cross-sectional study, employing census survey of all the 41 eligible nurses working in the hospital was done. Data was obtained by means of a structured questionnaire. Informed voluntary consent and all other ethical clearances were obtained. The data obtained was analyzed using SPSS version 20.A third of nurses were from maternity department. On gender aspect, female nurses were more than male nurses. Most nurses had strong perceived competency in provision of psychiatric care especially in the area of therapeutic communication. The perceived competency did not significantly differ across the nurses' qualifications neither did it significantly vary from one department to another. However, the study revealed significant variation in perceived competency across the various years of experience. Moreover, the perceived competency in conducting psychiatric assessment had a significant influence on the ability to provide psychiatric care. Likewise, the perceived intervention competency had an influence on the ability to provide care. However, there was no relationship between perceived communication competency and ability to provide psychiatric care. The study concludes that perceived competency in the provision of psychiatric care is significantly influenced by the nurse's working experience, perceived competencies in psychiatric assessment and perceived ability to give the needed interventions. Arising from the foregoing findings, this study recommends as follows: regular assessment of nurses' competencies to form need based capacity building, especially for nurses with more than four years' experience; and exploring opportunities of encouraging nurses to seek assistance with competencies they have deficiencies in. One such option is to have standby teams for peer-to-peer online anonymous consultations.

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ACRONYMS AND ABBREVIATIONS

ACMHN	Australian College of Mental Health Nurses
BCMHL	Bazelon Center for Mental Health Law
BHCC	Behavioral Health Care Competency
CIRN	Competency inventory for registered nurses
DACUM	Developing a curriculum model
IBM	International Business Machine
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Stardand
LR	Likelihood Ratio Chi-Square Test
LSCH	Loitokitok Sub County Hospital
MOH	Ministry of Health
MSA	Mental Status Assessment
NACOSTI	National Commission for Science, Technology & Innovation
NASMHPD	National Association of State Mental Health Program Directors
NCK	Nursing Council of Kenya
OPD	Out Patient Department
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
USA	United State of America
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Psychiatric health is a state of emotional well-being which enables concurrent success in mature and cordial relationship at work, home and within the community with the capacity for flexible conflicts resolution between instincts, conscience, other people and reality leading to satisfaction with one's own achievements (Mohr, 2003; World Health Organization [WHO], 2005). In the United States, current estimation indicates that only 17 percent of adults have voluntary psychiatric health. Psychiatric health has been neglected for a long time as an unmet public health need due to historical separations of health care and psychiatric care. There has been much current effort within public health to integrate behavioral health issues and recognize the need for improved mental health to truly achieve the overall wellness of an individual (Bazelon Center for Mental Health Law [BCMHL], 2012). Psychiatric health, both suboptimal and optimal, is passed on from generation to generation and within communities. Individuals through their families and communities learn cope with and mediate stress, and receive support that promote resilience (Avison, 2010; Clarke et al 2011).

Psychiatric health nursing is an area that entails promotion and maintenance of mental health through psychiatric assessment, diagnosing and provision of necessary interventions for human responses to mental disorders(Reed & Fitzgerald, 2005;Hanrahan&Gerolimo, 2004). The psychiatric health nurse is trained on diagnosing mental disorders, using mental health screening tools, managing mental disorders and providing psycho education, cognitive behavioral therapy, and

psychotropic drug therapy (Hanrahan, 2009). Ideally, acute inpatient psychiatric services are offered mostly by psychiatric nurses specialized in this area. However, due to the current acute shortage of these experts (Appelbaum, 2007; Kabir et al, 2014; Patzel et al., 2007)deployment of general nurses in caring for clients with mental ailments has become inevitable(Arnold & Mitchell, 2008; Hanran& Gerolamo, 2004).General Nurses may have no confidence in their ability to intervene properly and precisely to propose psychotropic medications when necessary (Arvidsson, 2011; Appelbaum, 2007; Sharrock & Happell 2006). Lack of appropriate intervention may result to increased re-admission, prolonged length of stay leading to financial implications for this patient population (Katschnig, 2006).

To deliver quality care to patients with psychiatric disorders, health workers ought to feel and demonstrate that they have competency in their trade. Availability of various definitions makes it difficult to conclude what competence and competency really are and therefore making it unlikely to ever have universally acceptable definitions. Garside (2013) of United Kingdom used a systematic approach to try and reveal any factor that can help people understand the meaning. The investigation only helped to make it more complex with more specifications and explanations of competence and competency in nursing practice. The capacity of a nurse to work efficiently with a display of knowledge, skills, judgment and attitude necessary in a definite area of practice is deemed as competence (Garside, 2013; Levett-Jones, et al, 2011; Eales, et al, 2014; Honeycutt et al, 2014). In English language the terms competency and competence can be used alternatively (Hagar & Gonczi, 2009; McMullan et al., 2003). On the other hand in assessment literature and medical education, competence is

ability to perform a skill while competency is used for the skill itself (Walker & Avant, 2005).

In this study the researcher adopted the word competency; competency comprises the perceptions of ability to perform psychiatric assessment, use therapeutic communication and provide appropriate intervention to psychiatric patients. The perceived competence is subject to a number of issues. First, is the relevant training; Evidence has shown that nurses with no psychiatric training perceive themselves as not being confident with their knowledge and skills in the assessment and intervention in psychiatric care(Sharrock & Happell, 2006). They have perceptions of inadequacy and fear especially when dealing with patients with self-inflicted harm (Appelbaum, 2007; Arvidsson, 2011 ;Sharrock & Happell, 2006). The general nurses perceive they are inadequately trained and are not prepared to deal with patients with mental health disorders(Clark et al., 2005). The perception of lack of competencies by general nurses may result to inability to provide appropriate psychiatric care (Sharrock & Happell, 2006).

Second is the experience and exposure. A study on the construction of competence in mental health nursing observed that during practice, nurse prescribers construct competence through an interactive process of owning and demonstrating competence(Snowden, 2012). Similarly, Sullivan (2013) maintain that experience, adequate practice and training shape the nurses' self-confidence to provide care.

To ensure quality and patients safety, some countries have developed the national competencies for various cadres of nurses who could not be trained on mental health but are assigned to patients with mental illnesses. Australia, for example, has developed national competencies for various cadres of nurses which guides training

and evaluation of nurses working in different professional areas (Halcomb et al., 2018; The Australian College of Mental Health Nurses [ACMHN], 2020). Unlike these countries, Kenya does not have national competencies for general nurses providing care to mentally ill patients(Nursing Council of Kenya [NCK], 2012). Despite this lack of nationally prescribed competencies for general nurses, efforts have been made to equip these workers with the skills they need to fill the gap created by shortage of specialized psychiatric nurses(Jenkins et al., 2010).Jenkins et al have identified the necessary skills and proposed that short courses and Continuous professional development sessions be conducted to build the capacity of general nurses providing care to mentally challenged patients in Kenyan context.

1.1 Statement of the problem

Throughout the world awareness of mental illness as a significant cause of morbidity has increased. With the awareness increase is a steady decrease in trained psychiatric mental nurses due to aging and retirement and lack of replacement (Hanrahan, 2009; Kabir, et al, 2014). The World Health Organization recommends a ratio of 1: 12 that is one psychiatric nurse to care for 12 patients per shift (WHO, 2001). Kenya has around 500 psychiatric nurses, of who only 250 practice psychiatric nursing and are deployed at the national and county levels (Ogugu, 2015). They are able through experience to access the required interventions to avert adverse outcomes or inappropriate events (Rutledge, et al, 2012).

With the shortage of specialized nurses it is inevitable for general nurses to give psychiatric care especially in rural areas (Appelbaum, 2007). General Nurses are not specialized and may have no confidence in their capacity to provide appropriate interventions to include recommending psychotropic medications when appropriate

(Appelbaum, 2007; Arvidsson, 2001; Sharrock & Happell, 2006). To deliver quality psychiatric care to patients with psychiatric disorders, health workers ought to feel and demonstrate that they are competent in their career. However general nurses working in general or other non-psychiatric units may lack behavioral healthcare competency to manage disruptive behaviors linked with psychiatric illnesses (Rutledge et al, 2012).

Competency in service delivery is either real or perceived. Nurses' self-perceptions on their know-how to offer services influences their confidence; and ultimately the quality of patient care (Lim et al., 2020). However, there is shortage of literature on nurses' perceived competencies in psychiatric care in Kenya; and particularly in Loitoktok Sub-County Referral Hospital. This is a concern especially since shortage of specialized psychiatric nurses has made it inevitable to deploy general nurses to care for patients with mental illnesses(Jenkins et al., 2010). For example, anecdotal evidence from the records in the patient's files of seventy (70) psychiatric patients admitted at Loitokitok hospital between December 2018 and May 2019 revealed that; none of the patient had their full history and specifically psychiatric history taken on admission and neither baseline nor subsequent mental status assessment was done. Lack of adequate psychiatric assessment may lead to misdiagnosis and may result to frequent cases of relapses which may crudely imply suboptimal interventions. In the light of above evidence, there is a need to prepare the general nurses on psychiatric care which should be informed by the level of their competencies of which is currently not known. Therefore, the study aimed at assessing nurses' self-evaluation of their competencies in the care of psychiatric patients at Loitokitok Sub County Hospital.

1.2 Study Purpose

To assess nurses' perception of their competencies in the provision of psychiatric care at Loitokitok Sub County Hospital

1.3 Study Objectives

1. To assess Loitokitok Sub-County Hospital nurses' perception of their competency in performing psychiatric assessment.
2. To evaluate Loitokitok Sub-County Hospital nurses' perception of their competency in therapeutic Communication in the provision of psychiatric care
3. To determine Loitokitok Sub-County Hospital nurses' perception of their competency to intervene in psychiatric care.
4. To determine whether there is an association between nurses' length of professional experience and perception of their competencies to provide psychiatric nursing care at Loitokitok Sub-County Hospital

1.4 Research questions

1 What are the nurses' perceptions of their competencies to perform a psychiatric assessment?

2 What are the nurses' perceptions of their psychiatric therapeutic communication competencies?

3 What are the nurses' perceptions of their competencies in implementation of interventions in psychiatric care?

4 What is the association between nurses' length of professional experience and perception of their competencies to provide psychiatric nursing care?

1.5 Justification of the study

The high prevalence of mental disorders and mainstreaming of psychiatric care have necessitated psychiatric patients to be provided with care by general nurses in general hospitals. With the increasing prevalence of mental illnesses and shortage of specialized psychiatric nurses, general nurses will continue to provide the bulk of the psychiatric care. However general nurses report various challenges in provision of psychiatric care. In the absence of national competencies for general nurses in provision of psychiatric care, understanding current general nurses' perception of their competencies was important for improving psychiatric care in Kenya, with particular focus on Loitoktok Sub-County Referral Hospital.

1.6 Significance of the study

In theory evidence from this study may impact policy, programs, and strategies aimed at quality assurance mental care; including aspects of orientation, mentorship and Continuous Professional development. This investigation has also identified felt gaps among nurses on their competencies. In addition, this enquiry potentially elicits discourse on the need for professionally prescribed mental health nurses' competencies, for general nurses.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter introduces a review of the related literature on nurses' perception of their competences in the provision of psychiatric care. This section is organized along these lines: The concept of competency; the essential competencies in psychiatric nursing, nurses' experience in shaping the perceived competencies and gaps identified from the review. Additionally, the section highlights the theoretical and conceptual framework underpinning this enquiry.

Literature was obtained from several sources, namely online search engines like google scholar and books, to mention a few. The documents searched include the peer-reviewed journal article published between 2000 and 2020, books and policy papers. The search was guided by the following keywords - *Mental health, Psychiatric care competencies, clinical competence assessment and psychiatric evaluation.*

2.2. Theoretical review.

Concept of competency: Meaning and measurement

Since primary health services are mostly offered by general nurses especially in Africa, they should be able to demonstrate competency in the care of psychiatric patients (Appelbaum, 2007; Arnold & Mitchell, 2008; Levett-Jones, et al, 2011).The capacity of a nurse to work efficiently with a display of knowledge, skills, judgment and attitude necessary in a definite area of practice is deemed as competency(Eales et al., 2014; Garside & Nhemachena, 2013; Honeycutt et al., 2014; Jenkins et al., 2010; Levett-Jones et al., 2011). The core competencies needed in psychiatric care includes

psychiatric assessment from which diagnoses of mental disorder are derived (Kaplan &Sadock, 2017), the therapeutic communication between the patient and the nurse (Mohr, 2003) and appropriate intervention in psychiatric care. Snowden (2012) studied on the creation of competence in mental health nurse prescribing for psychiatric patients. The study revealed that in practice, nurse prescribers construct competence through an interactive process of owning and demonstrating competence. Nurse competency may be preceded by external and personal motivations. These attributes include experience, proficient skills, adding knowledge into practice, portraying professionalism and critical thinking. These will lead to outcomes which include confidence, safe practice, and holistic care (Sullivan, 2013).

Competency in service delivery is either real or perceived. This study focused on the know-how as professed by nurses themselves. The self-evaluation is dynamic. Nurses can perceive themselves as inexperienced practitioners in one area and being expert in another aspect of a competency(Eales et al., 2014). Eales et al. contend that any instrument developed should be cognizant that performance may vary depending on conditions the nurse find themselves in. Attempts at developing tools measuring nurses' competencies have been made. Examples of these instruments are;

(i) Competency Inventory for Registered Nurse (CIRN) by (Liu et al, 2007).The tool for assessing competence was developed in the year 2007 by Liu and others (Liu, et al., 2007). The instrument has 7 dimensions which consist of 55 components. One aspect of the instrument is medical care which has 10 components. The others are leadership with 9 components while interpersonal relationships, legal-ethical practice and research aptitude-critical thinking has 8 components each and lastly professional development and teaching-coaching each with 6 components. Peer and self –

evaluation of nurses in the clinical area can be done using this instrument (Liu et al 2007).The five-point likert scale is used to score CIRN at a range of 0 to 4. Incompetency is scored at zero while very high competency is scored at 4. Low competency is scored at one (1), two (2) is an average competency and a score of three (3) is high or sufficient competency. A mean score of below 2 is considered to be low competency, 2±3 is average and above 3 is a high (Liu, et al 2007; Liu, et al, 2009). Evaluation of instrument reliability was determined using alpha coefficient. The whole instrument had a Cronbach's alpha of 0.97 which was expressed in the range of 71% - 90% for its aspects (Ghasemi, et al, 2014). The instrument had a content validity of 85% (Liu, et al, 2009).

(ii) Behavioral Health Care Competency (BHCC) suggested by (Rutledge et al, 2012). The BHCC instrument was developed and validated by Rutledge and others in 2012. They administered it in a study to actuate the feeling of hospital nurses towards their individual competencies (Rutledge et al, 2012). The instrument was designed to measure four (4) basic competencies in psychiatric care. This is to include psychiatric assessment, interventions in psychiatric care, ability to recommend psychotropic drugs, and adequacy of resources. The tool is a 5 level likert scale with 23 components that need responses with a score of one (1) to five (5) which means the respondent strongly disagree or strongly agree respectively. A high score indicates the respondent has a high feeling of competency. The whole tool was found to have a coefficient of .92.

(iii)Developing a curriculum model (DACUM) Performance Rating Scale. This tool was found to be a creditable competency assessment tool which grades the level of achievement from 0 to 6.Zero (0) being inexperienced practitioner in a field, three (3)

a Competent practitioner and six (6) an Expert practitioner. The DACUM Performance Rating Scale gives the supervisor and the practitioner the ability to estimate the degree of achievement in every area of the competency framework. Nurses can perceive themselves as inexperienced practitioner in one area and being expert in another aspect of a competency which means that nursing is dynamic. The instrument recognizes that performance may vary depending on condition the nurse find themselves in, that is competence tend to fluctuate depending on a given condition or a certain time period. To further discriminate levels of achievement the grading, or scoring, system is used. Combining the scores from all competencies enable one to determine an overall level of achievement and performance which give the practitioner a feeling of advancement in all areas of their work(Eale, et al, 2014). This concurs with Heydari et al (2016) nurse's self-evaluation on their overall nursing competences which they rated good and very good.

Issues that influence self-competency evaluation.

The perceived competence is subject to a number of issues.

i) Training

Nurses providing psychiatric care should be well prepared in terms of appropriate education, competence and expertise to provide care for patients with mental health illnesses (Sharrock & Happell, 2012).The core competencies include psychiatric assessment which is taking psychiatric history and performing mental status assessment of the patient/client from which diagnoses of mental disorders are derived (Kaplan &Sadock, 2017).Therefore psychiatric health nurse is trained on diagnosing mental disorders, using mental health screening tools, managing mental disorders and providing psycho education, cognitive behavioral therapy, and psychotropic drug

therapy (Hanrahan, et al, 2006). Evidence has shown that nurses with no psychiatric training perceive themselves as not being confident with their knowledge and skills in the assessment and intervention in psychiatric care (Sharrock & Happell, 2006). They have perceptions of inadequacy and fear especially when dealing with patients with self-inflicted harm (Appelbaum, 2007; Arvidsson, 2011; Sharrock &Happell, 2006).

Nau, et al, (2007) did a study in Germany about student nurse experiences in managing patient aggression. The study revealed that managing aggression is a general challenge which is not confined to psychiatric settings alone and therefore nursing students need to be prepared in training so as to acquire knowledge about aggression and be aware of the contributing problems. Nursing students should also be trained to be assertive and have capability in dealing with aggressive patients and also should be able to show understanding in communication and the ability to cope in an appropriate manner.

The general nurses perceive they are inadequately trained and are not prepared to deal with patients with mental health disorders (Clark et al., 2005). The perception of lack of competencies by general nurses may result to inability to provide appropriate psychiatric care (Sharrock & Happell, 2006). However, Rutledge, et al, (2012) argued that the general nurses working in acute care settings and have some training in basic assessment of inappropriate and disruptive behaviors feel that they can intervene more appropriately. Disruptive behaviors include aggression, agitation and psychotic episodes.

Peplau (1988) argued that nursing skills develop with time over time through experience and proper basic nursing education. Reed and Fitzgerald (2005) assert that over time, nurses gain adequate knowledge and skills; making them feel more competent in caring for clients with behavioral health needs. Rutledge et al, (2013) did

a study on staff nurse perceptions of competency to care for patients with psychiatric or behavioral health concerns. The findings indicated that despite perceived availability of resources, nurses were less confident in interventions such as acting in situations that require techniques in de-escalation or crisis communication than in their ability to assess patients in their areas for psychiatric/behavioral health needs. They are able through experience to access the required interventions to avert adverse outcomes or inappropriate events.

A different study by Casey et al. (2004) echoes the above findings. In their study of graduate nurses' experiences, Casey et al. noted that nurses with less than a year of working experience felt incompetent, uncomfortable and anxious to offer care to patients. As a result, the research recommended an elaborate orientation program to enable graduate nurse's transition to the work place. Pfaff et al.(2014) made similar observations and went further to suggest that if nurses are not helped to feel competent enough to provide care, patient safety may be compromised. Snowden (2012) studied on the construction of competence in mental health nurse prescribing for psychiatric patients. The study revealed that in practice, nurse prescribers construct competence through an interactive process of owning and demonstrating competence. Nurse competency may be preceded by external and personal motivations. These attributes include experience, proficient skills, adding knowledge into practice, portraying professionalism and critical thinking. These will lead to outcomes which include confidence, safe practice, and holistic care (Sullivan, 2013).

According to Leaf, et al (2010) most general nurses perceive that assessment and management of patients experiencing a mental illness is outside their scope of practice or not part of general nurse competencies. He asserts that modification of nursing

curriculum is necessary and mental illness among mentally ill patients and nursing personnel be given an opportunity to update their knowledge periodically. A well equipped nurse educator with proper knowledge may be able to develop students and staffs with competencies in care of mentally ill patients and can provide proper health education to caregivers of mentally ill patient. Conferences, workshops, seminars can be held for nurses on mental illness Nurses' experience and perceived competencies he concludes.

Theoretical Foundations

This research is anchored on first, Theory of Interpersonal relation by Peplau (1988). In her 1952 theory, Hildegard Peplau made four assumptions regarding patient nurse-relationships: 1) patients and nurses must interact; 2) the therapeutic interaction provides an opportunity for such a relationship to mature; 3) nurses must exploit communication skills in nurturing this relationship; and 4) nurses ought to be self-aware so that their values do not limit the clients' choices and behaviors (Peplau, 1988).

Peplau posited that successful therapeutic relationships grow through three overlapping phases: Orientation, working, and termination stages. During the orientation phase, the patient demonstrates help-seeking behavior, and attempts to seek assistance from qualified persons (Senn, 2013). The patient and nurses cultivate trusting relationships. The nurse gathers information about the patient, creates an initial impression of clients' needs, interests, experiences and fears. In the course of the working phase, the nurses characteristically deploy their knowledge, skills and time to solve patients' problems. The nurses should be consistent and provide unconditional positive regard throughout the interaction. The patient should

progressively become independent with personal care. The interaction ends at the termination phase. According to Peplau, the parties disengage from the nurse patient relationship. In particular, nurses appraise patients with the discharge plan. In addition, nurses help patients draw a plan towards self-reliance.

The nurse's actions are guided by interpersonal principles envisaged by Peplau's theory. In this study, therapeutic communication was key. The study explored how this skill was deployed during patient care. The emphasis was how the nurse chose to communicate during various activities of patient care; namely psychiatric assessment, diagnosis and treatment. Communication competency is having the capacity to choose a communication behavior that is both adequate and relevant for a given situation (Spitzberg & Cupach, 2012). According to Peplau, as nurses mature in their profession and interactions, communication improves.

Second, Dreyfus and Dreyfus framework of tracing the nursing competency from novice to expert practitioner. Dreyfus (2004) argued that there is partial acquirement of skilled performance through principles and theory learned in a classroom but only in clinical practice that the critical context-dependant judgments can be obtained. Over time, nurses gain adequate knowledge and skills; making them feel more competent in caring for clients with behavioral health needs. They are able through experience to access the required interventions to avert adverse outcomes or inappropriate events. To assess the level of nurse competency Benner (1984) applied the Dreyfus model to nursing and drew up a framework that pursued the development of nursing skill and expertise from novice to expert practitioner. She discussed the role of experience in redefining preconceived notions. Self-confidence in ability to assess psychiatric clients is dependent on training and experience as revealed in the literature review. The model

has been adjusted and customized to explain skills acquisition in nursing (Benner 2001). The application of the improved Dreyfus model allow grading candidates as incompetent, novice, advanced beginner, competent, proficient, expert or masters (Benner 2001). Grading against these levels on the Dreyfus model will be made possible when qualities and observable behaviors are attached to each of these levels, for particular skills in different specialties. The improved Dreyfus model will allow formulating a scoring rubric to record the level of performance being displayed by the candidates during the assessments in workplace (Benner 2001).

2.3. Empirical Literature on Psychiatric care competencies.

i) Psychiatric assessment competencies in the provision of psychiatric care

Nurses are the health professionals in first line contact with people encountering mental illness and therefore have a key role in the identification of psychiatric health problems and subsequent care(Sharrock & Happell, 2006). They require doing psychiatric assessment to patients with medical diagnoses, evaluate any associated risk through the medical records and attend to family members concerns(Nadler-Moodie, 2012). Mental status assessment (MSA), conducting a systematic assessment of the patients' mental functioning, is important in this regard. It is used to establish the psychological functioning on admission and also facilitate diagnosis. A subsequent assessment is done which enables the nurse to evaluate changes in the patient over time and response to treatment (Kaplong & Sadock, 2017; Mohr, 2003).This is well within the duty of the nurse; which is to perform detailed and organized evaluation; and together with the healthcare team, patients and families create a plan of care and enforce documentation efficiently(Kelly, 2007). Through evaluative thinking the nurse should re-assess and change care plan depending on the patient response to interventions? This includes both objective observations of the nurse and subjective

descriptions given by the patient (Mohr, 2003).The observations made in the ward during hospitalization are important because for example a patient may deny having hallucinations during the interview on admission but the nurse may note him running from invisible people and claiming that they want to kill him (Townsend, 2015).

Comprehensive Mental Status Assessment done on admission mayattain a comprehensible display of all factors which may have an influence on the patient's mental state and adequate information is elicited to aid in distinguishing the symptomatology of different mental disorders (Zieschang, 2010). Distinguishing psychiatric symptoms from medical conditions may be challenging for nurses in delivering care. It require the nurse to deal with the symptoms of the psychiatric disorder itself, the comorbid medical condition and the problems originating from possible patient-nurse interpersonal communication (Kelley, et al, 2008;Palmu, et al, 2010;Zieschang, 2010). As a result the nurses' perception for care for such patients may be deemed as uncomfortable, difficult, unrewarding and stressful (Zieschang, 2010).

As the nurse continue to interview the patient during the Mental Status Assessment, a feeling of safety and respect is developed and the patients feel increasingly free to share their problems (Townsend, 2015). MSA help the patient to gain sufficient confidence in the nurse's willingness to understand them (Mohr, 2003). The nurse develops an understanding of the patient's problems and is able to develop an effective care plan and thus effective nursing interventions in collaboration with the patient (Kaplong&Sadock, 2017; Mohr, 2003; Townsend, 2015;). Changes in the patient and response to treatment can only be elicited through Mental Status Assessment and the nurse is able to know when the patient is ready for discharge or when the patient is not

responding to treatment and need to be adjusted or changed (Townsend, 2015; Mohr, 2003). This might mean that utilization of Mental Status Assessment may positively or negatively affect the patient's outcome (Townsend, 2015; Mohr, 2003).

Despite the benefits of MSA, nurses in most hospitals and clinics are yet to comprehend and implement the approach to solving patient's problems (Townsend, 2015). In as much as inadequate staff could be the issue, increased workload and inappropriate material for documentation could also be contributing to the general nurses' perception of lack of competency. It is also argued that most issues related to psychiatric care by nurses are mainly attributed to inappropriate interpersonal communication, feeling of inadequacy and professional dissatisfaction caused by skill deficits and knowledge gaps(Arnold & Mitchell, 2008). Additionally, the literature review reveals that general nurses feel that psychiatric evaluation and intervention of patients experiencing a mental illness is not within the area of their practice and is not part of a general nurse competencies (Appelbaum, 2007; Arvidsson et al., 2011; Sharrock & Happell, 2006). Moreover, self-confidence in ability to assess psychiatric clients is dependent on training and experience(Casey et al., 2004; Pfaff et al., 2014; Reed & Fitzgerald, 2005). And so, nurses providing psychiatric care should be well prepared in terms of appropriate education, competency and expertise to care for people with mental health disorders(Sadock et al., 2017; Sharrock & Happell, 2006).

ii) Therapeutic communication competencies in the provision of psychiatric care

Central to psychiatric assessment, diagnosis, treatment and ultimately recovery are effective communication. Communication competency is having the capacity to choose a communication behavior that is both adequate and relevant for a given situation(Spitzberg & Cupach, 2012).Therapeutic communication competency allows

both parties to achieve the intended communication goals while maintaining their self-image. It is the ability to interact well with others.

An investigation on the therapeutic skills of a mental health nurse by Fisher(2013) revealed that physical and psychiatric evaluation skills were the most effective skills for psychiatric care. He continues to say that nurses communicate to patients using various channels to ensure that appropriate information get to all those involved in the patient's care. Effective communication and counseling skills is a competency that empowers therapeutic relationship with clients and thus a recovery oriented approach. According to Bartlett et al. (2008), hospitalized patients with psychiatric disorders were more than twice as probable as those without psychiatric disorders to have a preventable unfavorable incident originating from a communication problem.

A number of issues affect therapeutic communication. It is argued that attitude towards psychiatric patients hamper communication which has a negative impact on care (Gebbie & Qureshi, 2002). Reed and Fitzgerald (2005) in a study in a general hospital to assess the feeling of nurses toward caring for patients with both physical and mental illnesses recommended that continuous education and supportive environment towards nurses offering psychiatric care is necessary in improving care for psychiatric patients. Likewise it has been concluded that where there is a positive therapeutic communication between a healthcare provider and a patient, the patient is able to handle a long standing medical illness effectively and be able to prevent complications(Jeffreys, 2010). In particular, patients are often contented with services where health providers share information promptly, and are empathetic to patients (Spitzberg & Cupach, 2012).As the nurse continue to interact and communicate with

a patient, a feeling of safety and respect is developed and the patients feel increasingly free to share their problems (Townsend, 2015).

A good therapeutic environment for the nurse and the patient enables them to plan together for the care of the patient effectively which may lead to a short duration of hospitalization (Townsend, 2015; Mohr, 2003). Leininger and McFarland (2006) held that the extent to which the goals of interaction are achieved determines the degree of communication competency. A Health Provider who is able to relay information, listen to the patient and empathize with them, contribute to positive health outcomes which result to patient being contended and appreciative of the services rendered (Spitzberg & Cupach, 2012). Effective communication skills like any other health care procedure can be learned and improved but it requires commitment and practice(Gilje et al., 2007).

iii) Interventions in psychiatric care.

The common conditions seen in psychiatric patients admitted in general care hospital units are psychosis, delirium, anxiety, aggression, abuse of substance and withdrawal, bipolar disorder, personality disorders, and suicidal ideation or behavior (Nadler-Moodie, 2010). Alcohol and other mind-altering drugs are usually the reason for agitation and violence in the casualty department (Nadler-Moodie, 2010; Nordstrom, et al., 2012). Withdrawal from alcohol and drugs can also be a cause of agitation (Nordstrom, et al., 2012). Hospitalized patients without mental illness may experience fear and anxiety that may cause disordered behaviors (Nadler-Moodie & Gold, 2005; Nadler-Moodie, 2010). Similarly psychiatric patients when admitted to non-psychiatric setting may be aggressive and disruptive displaying disordered behaviors with verbal aggression, nervous excitement and psychotic episodes (Nadler-Moodie,

2010). Such patients are termed to be unpredictable and the health professionals may associate them with violence and disruption (Björkman, et al, 2008; Zolnierek, 2009) and consequently avoid or treat them with caution.

Interventions competency entails all those actions that aim at restoring, promoting and enhancing a sense of well-being in a psychiatric patient (Binder & Wechsler, 2010). Nurses' interventions should try to avoid upsetting patients. They should ensure that they reduce the likelihood of environmental stimuli that lead to patient agitation and violent behaviors(Palmu et al., 2010). In that regard, maintaining a calm activity level, using a nonjudgmental voice to talk to the patient, as well as verbal de-escalation are some of the skills used to abate behavioral upsets to the patients (Knox & Holloman, 2012; Nordstrom et al., 2012; Strout, 2010).

Stubbs and Dickens (2008) argue that healthcare professionals are trained and prepared for prevention and management of aggression and violence through the use of various methods. These methods include physical intervention skills such as restraint and breakaway, active coercive techniques such as seclusion and rapid tranquilization, and interpersonal techniques to include de-escalation. According to Strout, (2010) it is important for all emergency department staff to have training in verbal de-escalation techniques to avoid the use of seclusion, restraint, or forced medication which may hurt the patient both physically and psychologically echoes Knox & Holloman (2012).Verbal de-escalation should be tried to calm down an agitated patient, before any type of restraint or seclusion is employed (Knox & Holloman, 2012). De-escalation is a key strategy in preventing the agitated patient from becoming violent (Strout, 2010).

However, a study by Clarke et al.(2005)revealed that psychiatric patients had a feeling that staff working in the emergency department did not have appropriate knowledge regarding mental health. In addition, the patients felt that their complaints were not regarded as valid but were just labeled and assessed as psychiatric patients. On the side of the service provider a study by Spence et al. (2008) revealed that Staff caring for psychiatric patients felt frustrated and perceived caring for them as stressful. Similar findings were established by Rutledge et al. (2013) in a study that focused on nurses' self-evaluation of their competency to care for psychiatric clients. The study reported that most nurses felt more confident in assessment of patients rather than managing patients requiring de-escalation techniques or crisis communication. More over nurses in general hospitals tend to place a higher priority on physical care than on psychosocial care (Wynaden et al, 2000). In two studies, nurses reported placing essential physical needs over mental health needs due to lack of time (Reed &Fitzgerald 2005; Arnold &Mitchell 2008). Other than time constraint study shows that basic human skills are significantly lacking in the nursing workforce especially in the acute settings (Armstrong, 2000).

Gaps identified.

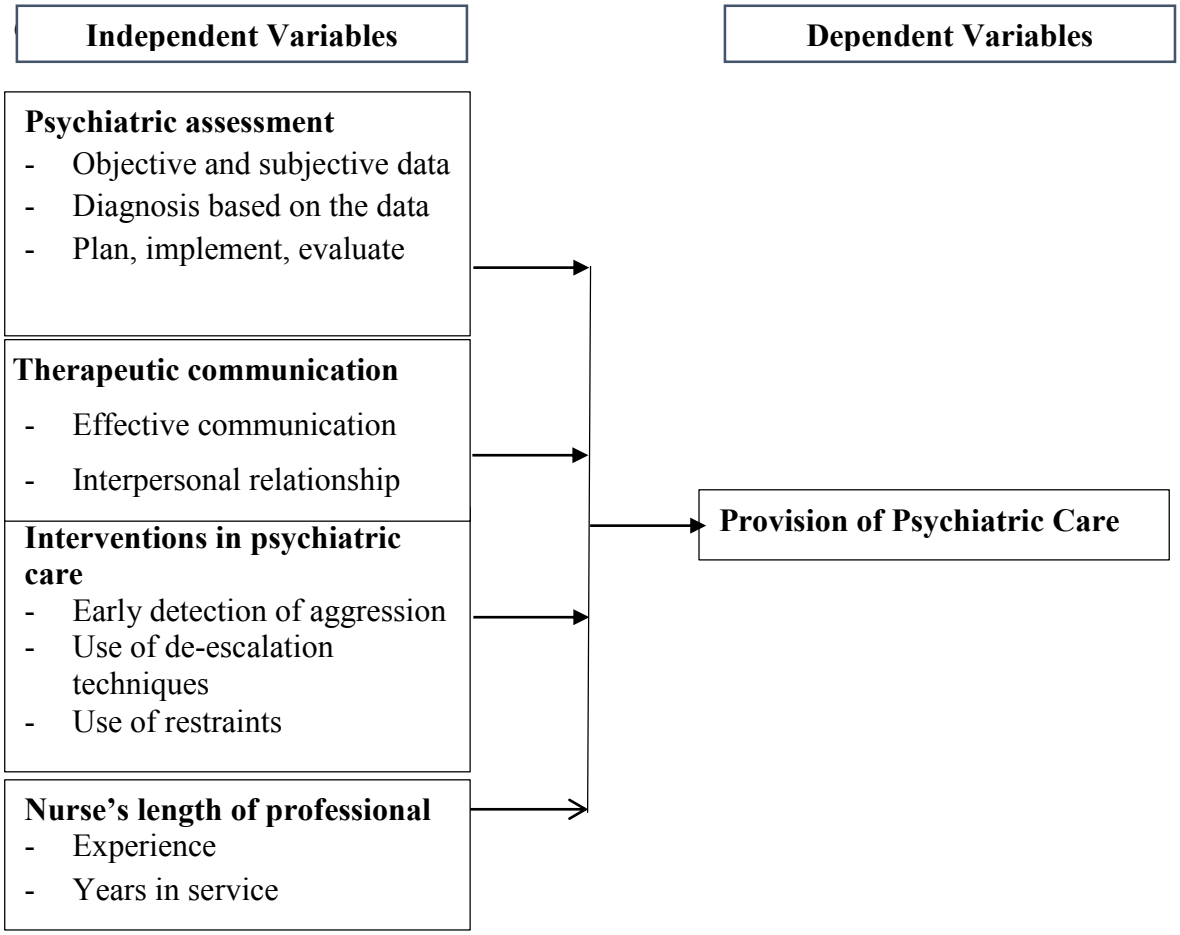
From the foregoing literature review there are a limited number of researches carried out on competency of non-specialized nurses especially in providing direct psychiatric care; that is Psychiatric assessment, communication and intervention. Additionally, there is no documented research on the nurses' competence and psychiatric care in Kenya. This is the gap this study intends to fill.

2.4.Conceptual framework

A conceptual framework is a scheme of variables a researcher operationalizes in order to achieve the set objectives (Oso & Onen, 2009). Mugenda and Mugenda (2008) argues that independent variable tries to show the total effect in the study. The study was guided by the following conceptual framework, which was used to explain the interrelationship between the variables.The conceptual framework (Figure 2.1), developed after in-depth literature review, identifies the variables that were of concern to this study. The independent variables in this study were the psychiatric assessment, therapeutic communication, intervention and years of experience. Dependent variable was psychiatric care. It is worth mentioning that the variables are potentially interdependent.

Figure 2.1

Conceptual Framework



2.5. Operational definition of terms

Attitude – perceive and act positively or negatively towards providing psychiatric care.

Basic Psychiatric Education- Psychiatric training which does not exceed four weeks which is in the current general nursing curriculum.

Competency – The perceptions of ability to perform psychiatric assessment use therapeutic communication and provide appropriate intervention to psychiatric patients.

General Nurses – Nurses who are unspecialized in psychiatric nursing but have basic psychiatric education provided in their nursing curriculum.

Psychiatric illness/disorder - Refers collectively to all diagnosable mental disorders or illnesses that are usually seen at the hospital.

Perception – The viewpoints of the general nurses about their experience of providing care to a psychiatric patient and how the nurses take in information related to psychiatric care.

Psychiatric care – The services provided to psychiatric patient by the nurse.

Psychiatric Nurse - nurse who has a post-basic training in psychiatric nursing. In addition to the scope of a general nurse, a psychiatric nurse has other competencies which are in line with this field of specialization (NCK 2012).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology which was applied in conducting the research. It describes the study design, study population, study area, sampling procedures, sample size determination, tools and methods of data collection, data analysis and method of data presentation. Additionally, this part outlines measures deployed to adhere to research ethics as well as assuring validity and reliability of the findings.

3.2 Study area

A study area is geography for which data is analyzed in a report and/or map. This study was conducted in Loitokitok Sub County Hospital. Loitokitok derives its name from a burbling spring called Enkitokitok. The sub county is located at the southern tip of Rift Valley province in Kajiado County and is categorized among arid and semiarid sub counties in Kenya. It is 100kms off Mombasa road from Emali. Loitokitok Sub County Hospital serves the whole Sub County as a referral Hospital for the facilities around it and also receives patients from Tanzania. Loitokitok Sub County Hospital has a catchment area of 6411 sq. km and serves a population of 25,169 persons (Kenya National Bureau of Standards [KNBS], 2015). Loitokitok Hospital is headed by a Medical Superintendent who is surgeon specialist and has four other specialists, one surgeon, one pediatrician, one physician and one obstetrics /gynaecology specialist. It has a hospital administrator, 5 Medical officers, 51 nurses, 9 Clinical officers, 2 dentists and 1 dental technologist, 3 pharmacists and 3 pharmacy technologist, 7 laboratory officers, among others. The hospital consists of an Outpatient department,

Maternal Child Health/Family Planning department, Maternity department, Female ward, Male ward, Main theatre, Pediatrics ward and TB Manyatta. It has physical actual 112 beds and 10 cots and T.B Manyatta with 75 beds. The hospital serves an average monthly number of 2890 outpatient department (OPD) attendance and 480 inpatients.

3.3 Research Design

A Research design is a plan and procedure for research that transverse the resolutions from general assumptions to specific methods of data collection and analysis (Creswell, 2009). The study adopted a quantitative approach because it sought to assess the nurses' perception of their competencies in provision of psychiatric care at Loitokitok Sub-County Hospital. This was due to questions addressed, the nature of data collected, the nature of the problem under consideration and the type of tool used. Quantitative methodologies are preferable if the questions are related to "how often" but in "why" and "how" questions, there is need for qualitative methods (Babbie, 2003). The study employed a descriptive survey research design where the researcher posed a series of questions to the respondents (Kumar, 2005). The method was appropriate since it allowed for collection of information such as those aimed at measuring attitudes, opinions or habits which the study aimed at (Mugenda & Mugenda, 2008). A cross-sectional survey was the specific design that was used in the research because data was collected at one point in time. The survey consisted of two parts, a series of demographic questions and the modified Behavioral Health Care Competency (BHCC) survey. The quantitative data was collected to describe the nurses' perceptions of their competencies at the said time of data collection. The data was self-reported since individuals were asked to respond to questions posed to them.

The choice of quantitative design was informed by the desire to describe and quantify the perceived psychiatric competencies among nurses.

3.4 Target population

A population is referred to as all elements, individuals, or units that meet the selection criteria for a group to be studied, and from which a representative sample is taken for detailed examination about which the researcher wishes to draw conclusion (Mugenda & Mugenda, 2008). The target population is the population with the basic attributes of interest in a study, and to which the findings may be generalized. Study population was all the 41 nurses in five (5) selected departments where nurses provide direct care to psychiatric patients. Out Patient Emergency Department had 6 nurses, Maternity department had 14 nurses, Female ward 7 nurses, Male ward 7 nurses and Pediatric ward 7 nurses totaling to 41 nurses. O'Leary, (2017) suggests that for a minimum statistical analysis, a sample of 30 may be sufficient. Thirty (30) is a boundary between small and large samples. All the 41 nurses were accessed during their various shifts within the duration of data collection. This is because all nurses had been recalled from annual leave due to the Covid-19 pandemic.

3.5 Sample size and sampling procedures.

A sample is a model of the population or a subset of the population that is used to gain information about the entire population, it is studied to enable the researcher make more accurate generalizations about the larger group (Mugenda & Mugenda, 2008). Kothari (2014) defines sampling as the process of obtaining information about an entire population by examining only part of it. Determination of the sample is guided

by the need to obtain a sample that is, as far as possible, representative of the population as a whole (Creswell, 2009).

The population of nurses at Loitokitok Sub County Hospital was relatively small and therefore the researcher adopted Census. A census is a survey of all the elements in the population (O'Leary, 2017). By adopting a census one was sure of the representative nature of the population and that the objectives of the study would be attained. A census gave data of all the individuals in the population and removed sampling error.

3.6 Exclusion criteria and inclusion criteria

Inclusion criteria

Included in the study were 41 nurses in five (5) selected departments where at some point had to give care to a patient with mental illnesses. Out Patient Emergency Department had 6 nurses, Maternity department had 14 nurses, Female ward 7 nurses, Male ward 7 nurses each and Pediatric ward had 7 nurses.

Exclusion criteria

Nurses working in departments, like operating theatres, that do not provide psychiatric care were excluded. Nurse specialist in mental health was also excluded. Also to be excluded were nurses who would not have given a consent but all did consent to the study.

3.7 Data collection instrument

This study used a structured questionnaire to collect primary data. A questionnaire is a technique of data collection in which each person is asked to respond to the same set of questions in a pre-determined order (Bhaumik, 2012;Saunder et al, 2011). According to Cooper and Schindler (2011) the use of structured questions on the

questionnaire allows for uniformity of responses to questions. The questionnaire was self-administered which was delivered directly to the respondent and later picked by the researcher. This is because, self-administration of the questionnaire is cheaper and quicker and it is above researcher's effect and variability. A questionnaire is convenient in collecting primary data from respondents as they fill them during their free time and when their own workload is manageable (Rowe, 2009).

A previously validated Behavioral Health Care Competency (BHCC) assessment tool (Rutledge et al., 2012) with slight modification was adopted because of its ability to answer the research questions. Permission to use the tool was requested in writing although no response was obtained. BHCC instrument was formulated to measure hospital nurses' perceptions of their behavioral healthcare competencies (Rutledge et al., 2012). It has four (4) subscales- assessment, practice/management, recommend psychotropic and resource adequacy. The researcher left the subscale of assessment in BHCC as it was. Modification of the practice/management, recommend psychotropic and resource adequacy subscales was done by merging them together to form two subscales of Therapeutic communication and Interventions in psychiatric care. No change of the content or the number of items was made. Besides the demographics data, the final tool had (3) subscales: assessment, therapeutic communication, and interventions. The subscales had a total of 23 items that used a five point Likert-type scale requiring responses from 5 = strongly agree, 4 = agree, 3 = neither agree nor disagree, 2 = disagree and 1 = strongly disagree which was designed to be easy and quick for respondents to complete(Kothari & Garg, 2014; Rutledge et al., 2012; Saunders et al., 2011).

3.8 Pretesting

The researcher adopted and modified a previously used instrument (Rutledge *et al*, 2012). However, to test the questionnaire, a pretest was conducted on four (4) conveniently selected staff that represented the area of the study. Based on the feedback from the pre-test a fourth question concerning the department where the nurses worked was added to demographic information and a final questionnaire developed.

3.9 Reliability of the tool

Reliability refers to consistency in the tool. There were three competencies of interest in this study namely; the psychiatric assessment competency, the therapeutic communication competency and the psychiatric care interventions competency. The internal consistency of the items in each subscale used in this research was computed using the data collected from the actual study and found acceptable (i.e. Cronbach's' of $\alpha>0.7$).

3.10 Validity of the tool

To generate items that answer the study objectives, in-depth literature of related studies was done. Besides, the items in the survey tool were borrowed from similar studies elsewhere, with slight modification to fit the Kenyan situation and make the tool less bulky. Further, necessary corrections were done after subjecting the tool to pretesting and peer review.

3.11 Data collection procedure

A self-administered structured questionnaire was delivered directly to the respondents by the researcher together with an introduction letter (Appendix 1). The study was

explained and consent acquired from the respondents (Appendix II). The filled questionnaires were then collected and checked for completeness at the point of collection to increase the response rate. For easy entry of data, the questionnaires were affixed serial numbers. The questionnaire items were coded appropriately which enabled the collected data to be entered into the SPSS spreadsheets.

3.12 Data Analysis and Management

The raw data was cleaned and edited to enable analysis. The coded data was entered into the computer and analyzed using IBM package for Statistical Package for Social Sciences (SPSS) version 20. Descriptive statistics that were derived from the demographic data as well as the competencies of interest were the frequency and percentages. The data was further subjected to chi-square test and Fisher's exact test, which are inferential statistics, to establish the association between the dependent variable 'psychiatric care' and demographic factors particularly personal experience in years worked in nursing. All statistical tests of significance were set at 95% Confidence level, which is widely acknowledged as conventional (Polit & Beck, 2012). A P- value of <0.05 was considered statistically significant. The quantitative results were presented using tables, figures, frequencies and percentages.

An average score of 3 or less in each subscale denoted 'low ability' and if greater than 3 denoted 'high ability'. This in essence dichotomized each perceived competency 'low ability' or 'high ability'. In the same way, at individual item level, a score of ≤ 3 denoted 'low' and if more than 3 denoted 'high'. The average score in the three competencies provided the overall ability to provide psychiatric care. The criteria were also used to dichotomize perceived ability to provide psychiatric care into high and low.

3.13 Ethical Considerations

Ethical considerations represent a moral stance that involves conducting research to achieve not just high professional standards of technical procedures, but also respect and protection for the people actively consenting to be studied (Payne & Payne, 2004). Throughout the study the researcher followed professional guidelines and adhered to ethical research considerations. This involved avoiding acts of misconduct in research, such as data fabrication, falsification and plagiarism.

An introductory letter was obtained from Kenya Methodist University Scientific and Ethics Review Committee to help obtain a research permit from the National Commission for Science, Technology & Innovation (NACOSTI). The research permit was used to obtain permission from Loitokitok Sub County Hospital training committee to carry out the research in the facility. Informed consent was sought from the respondents before delivering the questionnaire while confidentiality was ensured by omission of names from the tool. Anonymity was assured by omitting the name of the respondent on the data collection tool. The respondents were assured that the data gathered was confidential and was to be used purely for research work. The informants' identification was protected by making them anonymous in the final report.

3.14 Limitations

Limitation is something that is not under control of the researcher but may affect the study in an important way (Creswell, 2009). The area of study mostly had general nurses working and one psychiatry trained nurse. This limited the opportunities to compare perceived competencies of general nurses with psychiatric trained nurses.

Study findings were about the opinions and perceptions of nurses concerning their own practice and knowledge. The study did not test the actual practices or outcomes of practices. Further, the sample size was relatively small. Therefore, the findings may not be generalized to other hospitals.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This research set out to explore nurses' perceived competencies in the provision of psychiatric care at Loitokitok Sub County Hospital. Specifically, the study purposed to: assess nurses' perception of their competence in performing psychiatric assessment in the provision of psychiatric care at Loitokitok Sub County Hospital; assess nurses' perception in application of therapeutic Communication in the provision of psychiatric care at Loitokitok Sub County Hospital; determine nurses' perception in ability to provide the needed interventions in the psychiatric care at Loitokitok Sub County Hospital; and to determine whether there is an association between nurses' length of professional experience and perception of their competencies to provide psychiatric nursing care at Loitokitok Sub County Hospital.

Presented in this section are the findings and the discussion of the results as they relate to the cited objectives.

4.1 Response rate

The study registered an impressive response rate of 100% (Table 4.1). All the questionnaires were returned within the time designated, complete and properly filled. This was possible because the principal investigator administered the tools physically to all respondents. Polit and Beck (2012) argues that people are likely to respond when the researcher directly approaches them. The researcher also called those nurses who were on off duty and made arrangements to administer the tool when they were available

4.2 Demographic characteristics of the respondents

Table 4.1 summarizes the demographic features of the nurses who participated in this study. One third of nurses 34.1% (n=14) were from maternity department. Outpatient was least represented with 14.6% (n=6). Regarding working experience, 68.3% (n=28) had been working for more than 5 years while 31.7% (n=13) had worked for 5 years and below. On gender aspect, female nurses were more (63.4%, n=26) than male nurses. Concerning qualification, the greatest number of nurses, 75.6% (n=31) had attained diploma in nursing.

Table 4. 1

Demographic characteristics of the respondents

Characteristics	**Demographics**	**Frequency**	**Percentage**
Department/ward	Maternity	14	34.1
	Female	7	17.1
	Male	7	17.1
	Pediatrics	7	17.1
	Outpatient	6	14.6
	Total	**41**	**100.0**
Working experience (years)	0-4	13	31.7
	5-10	6	14.6
	11-20	11	26.8
	21-30	10	24.4
	30 and above	1	2.4
	Total	**41**	**100.0**
Gender	Male	15	36.6
	Female	26	63.4
	Total	**41**	**100.0**
Professional training level	Registered nurse	31	75.6
	Enrolled nurse	9	22.0
	BScN nurse	1	2.4
	Total	**41**	**100.0**

4.3 Internal reliability for data collected in each competency

There were three competencies under investigation: Psychiatric assessment, therapeutic communication and psychiatric interventions. In assessing the self-evaluation of nurses on these areas, subscales were used. To ascertain the internal consistency of data collected using various subscales, reliability coefficients were computed. Presented in this subsection are the results of the internal reliability calculations in each subscale, using the data collected in the survey.

4.3.1 Inter-item reliability test for psychiatric assessment subscale

A Sub-scale consisting of nine Likert scale items (Table 4.2 and Appendix III) helped nurses to self-evaluate their competency to conduct psychiatric assessment of the patient. To test the internal consistency of the scale, a reliability coefficient was computed (tables 4.2, 4.3 and 4.4.). The items yielded a reliability coefficient of 0.806 (Table 4.4)

Table 4. 2

Inter-Item Correlation Matrix for psychiatric assessment subscale

	B1	**B2**	**B3**	**B4**	**B5**	**B6**	**B7**	**B8**	**B9**
B1	1.000	.421	.283	.357	.329	.387	.224	.079	.129
B2	.421	1.000	.364	.610	.447	.248	.271	.280	.145
B3	.283	.364	1.000	.377	.429	.310	.334	.227	.283
B4	.357	.610	.377	1.000	.528	.297	.384	.346	.179
B5	.329	.447	.429	.528	1.000	.568	.352	.028	.163
B6	.387	.248	.310	.297	.568	1.000	.560	.196	.223
B7	.224	.271	.334	.384	.352	.560	1.000	.536	.384
B8	.079	.280	.227	.346	.028	.196	.536	1.000	.300
B9	.129	.145	.283	.179	.163	.223	.384	.300	1.000

Table 4. 3

Items analysis within the psychiatric assessment subscale

Subscale Item	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
B1	5.4146	5.399	.418	.289	.797
B2	5.5366	4.905	.534	.457	.782
B3	5.6585	4.780	.505	.286	.786
B4	5.5854	4.699	.603	.517	.773
B5	5.4634	5.055	.553	.556	.782
B6	5.5610	4.852	.538	.522	.782
B7	5.7317	4.501	.625	.540	.769
B8	5.9512	4.948	.409	.417	.800
B9	5.6341	5.088	.359	.187	.806

Table 4. 4

Summary of reliability Statistics psychiatric assessment subscale

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.806	.810	9

4.3.2 Inter-item reliability test for therapeutic communication subscale

A sub scale comprising of six items (Table 4.5 and Appendix III) was used to assess the nurses' perceived ability to communicate while providing psychiatric care. Cronbach's alpha was calculated as shown in tables 4.5, 4.6 and 4.7. The internal reliability coefficient for the items in the scale was 0.717(Table 4.7).

Table 4. 5

Inter-Item Correlation Matrix for therapeutic communication subscale

Subscale items	C1	C2_	C3_	C4_	C5_	C6_
C1	1.000	.290	.235	.262	.208	.373
C2	.290	1.000	.413	.150	.246	.552
C3	.235	.413	1.000	.156	.154	.660
C4	.262	.150	.156	1.000	.481	.172
C5	.208	.246	.154	.481	1.000	.162
C6	.373	.552	.660	.172	.162	1.000

Table 4. 6

***Item-Total Statistics for therapeutic communication* subscale**

Subscale items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
C1	3.5854	1.899	.401	.191	.698
C2	3.5122	1.806	.531	.339	.652
C3	3.7317	1.701	.544	.441	.647
C4	3.3171	2.322	.288	.263	.719
C5	3.2439	2.489	.329	.265	.721
C6	3.7073	1.562	.678	.556	.593

Table 4. 7

Summary of reliability Therapeutic communication subscale

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.717	.721	6

4.3.3 Inter-item reliability test for psychiatric care interventions subscale

The perceived ability to provide interventions for patients on psychiatric care was assessed on an eight item composite scale (Table 4.8). The Cronbach's alpha for the sub scale was 0.761 (Tables 4.8, 4.9 and 4.10)

Table 4. 8

Inter-Item Correlation Matrix for psychiatric care interventions subscale

	D1	D2	D3	D4	D5	D6	D7	D8
D1	1.000	.361	.257	.300	.431	.329	.065	-.026
D2	.361	1.000	.430	.570	.463	.585	.208	-.175
D3	.257	.430	1.000	.628	.436	.503	.119	.085
D4	.300	.570	.628	1.000	.460	.348	.162	.032
D5	.431	.463	.436	.460	1.000	.536	.019	-.150
D6	.329	.585	.503	.348	.536	1.000	.386	.175
D7	.065	.208	.119	.162	.019	.386	1.000	.513
D8	-.026	-.175	.085	.032	-.150	.175	.513	1.000

Table 4. 9

Summary of reliability psychiatric care intervention subscale

Subscale Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
D1	3.5122	4.706	.382	.224	.749
D2	3.4878	4.356	.567	.591	.715
D3	3.7073	4.412	.573	.504	.715
D4	3.6829	4.372	.582	.569	.713
D5	3.3171	4.622	.505	.480	.728
D6	3.6098	4.144	.685	.614	.692
D7	3.4878	4.806	.335	.401	.758
D8	3.5366	5.305	.101	.418	.797

Table 4. 10

Summary of reliability psychiatric care intervention subscale

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.761	.763	8

4.4 Nurses' perception of their psychiatric assessment competence

Figure 4.1 shows the overall Self-evaluation on Psychiatric Assessment Competency. In summary, 90.2% (n=37) strongly perceived they could conduct psychiatric assessment, compared to 9.8% (n=4) who thought otherwise.

Figure 4. 1

Self-perception on ability for psychiatric assessment

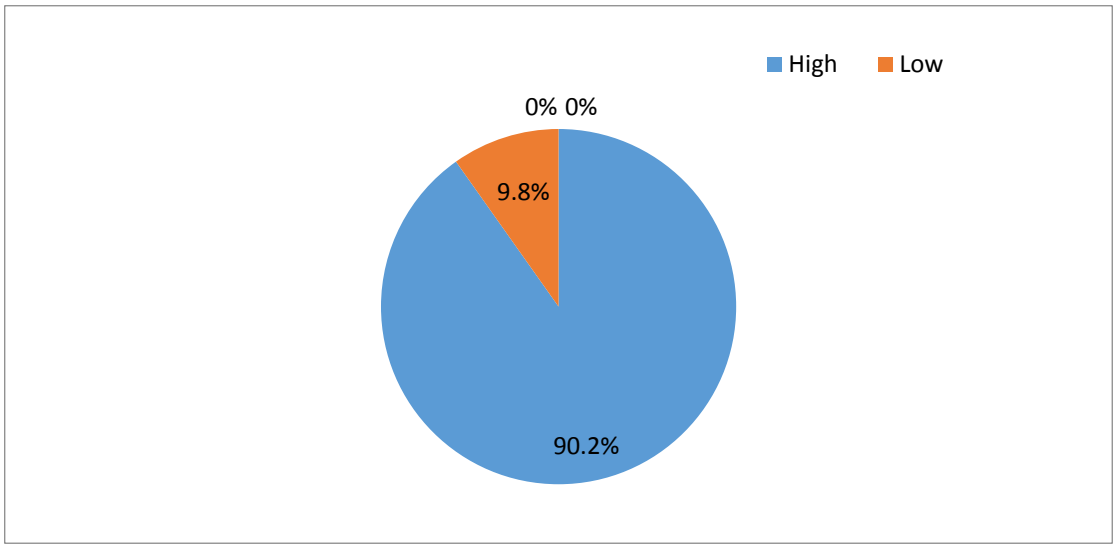


Table 4.11 shows the responses for each item in the Psychiatric Assessment Competency subscale. As shown in the table, most nurses had strong perceptions that they could comfortably assess the patient in the various areas that were presented to them. However, at individual item level most nurses 63.4% (n=26) had weak perception of their ability to distinguish between dementia and delirium.

Table 4. 11
Self-evaluation on psychiatric assessment competency

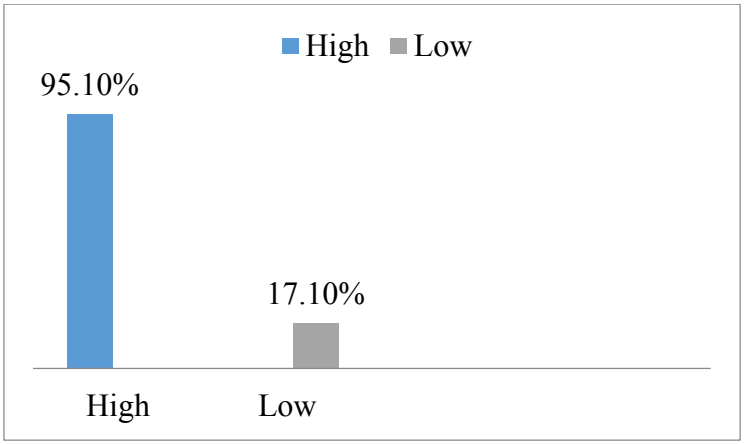
Self-evaluation on Psychiatric Assessment Competency Items	score	Frequency	Percentage
B1 I can assess patients for potential psychiatric problems.	Low	4	9.8
	High	37	90.2
	Total	**41**	**100.0**
B2 I identify signs and symptoms of common psychiatric conditions (e.g., depression, schizophrenia, bipolar disorder).	Low	9	22.0
	High	32	78.0
	Total	**41**	**100.0**
B3 I can identify common neuroleptic, tranquilizers, and antidepressant medications used with psychiatric patients.	Low	14	34.1
	High	27	65.9
	Total	**41**	**100.0**
B4 I am able to assess patients for risk of suicide (suicidality).	Low	11	26.8
	High	30	73.2
	Total	**41**	**100.0**
B5 I recognize behaviors that indicate a patient may have alcohol or drug abuse problems.	Low	6	14.6
	High	35	85.4
	Total	**41**	**100.0**
B6 I can recognize signs and symptoms of alcohol withdrawal.	Low	10	24.4
	High	31	75.6
	Total	**41**	**100.0**
B7 I can recognize signs and symptoms of drug withdrawal.	Low	17	41.5
	High	24	58.5
	Total	**41**	**100.0**
B8 I can distinguish between dementia and delirium.	Low	26	63.4
	High	15	36.6
	Total	**41**	**100.0**
B9 I can recognize the warning signs in patients whose behavior may escalate to aggression or dangerous behaviors.	Low	13	31.7
	High	28	68.3
	Total	**41**	**100.0**
Overall self-evaluation	Low	4	9.8
	High	37	90.2
	Total	**41**	**100.0**

4.5 Self-evaluation on ability to apply therapeutic communication

As shown in figure 4.2, overall, most nurses 95.1% (n=39) strongly perceived themselves having the ability to communicate effectively in all aspects of psychiatric care. Only 4.9% (n=7) felt incapable of communicating effectively.

Figure 4. 2

Overall self-evaluation on communication competency



On the individual items level (Table 4.12), most nurses had strong perception of ability to communicate in the care of psychiatric patients. However, 51.2% (n=21) had weak perception on the ability to use crisis communication and de-escalation techniques to distract aggressive behaviors, most of them 97.6% (n=40) called for outside resources when they perceived that the patients' behavior was beyond their ability to handle. Most 90.2% (n=37) had strong positive feelings that they knew when and where to ask for outside help when they needed it.

Table 4. 12

Self-evaluation on therapeutic communication competency

Self-evaluation on therapeutic communication competency Items	**Score**	**Frequency**	**Percentage**
C1 I am able to maintain a therapeutic relationship with most patients on my unit who have psychiatric issues.	Low	15	36.6
	High	26	63.4
	Total	41	100.0
C2 I can recognize and accurately interpret the patient's implicit communication by listening to verbal cues and observing non-verbal behaviors.	Low	12	29.3
	High	29	70.7
	Total	41	100.0
C3 I am able to use de-escalation techniques and crisis communication to avert aggressive behaviors.	Low	21	51.2
	High	20	48.8
	Total	41	100.0
C4 I know when to ask for outside help (e.g., physician, psychiatric nurse, other) for a patient with psychiatric issues or dangerous behaviors.	Low	4	9.8
	High	37	90.2
	Total	41	100.0
C5 I call for outside resources (e.g., physician, psychiatric nurse, other) when I recognize a patient's behaviors are escalating beyond my capabilities.	Low	1	2.4
	High	40	97.6
	Total	41	100.0
C6 I can effectively manage conflicts caused by patients who have mental problems	Low	20	48.8
	High	21	51.2
	Total	41	100.0
Overall self-evaluation	Low	2	4.9
	High	39	95.1
	Total	41	100.0

4.6 Self-evaluation on intervention competency

The performance at individual items level is shown in Table 4.13. The table shows that overall, 58.5% (n=24) of nurses were confident of their ability to initiate appropriate intervention in patient for instance having hallucinations. Most 65.9% (n=27) nurses felt they had no confidence to recommend psychotropic drugs to physician for use in psychiatric patient. Many nurses 56.1% (n=23) claimed that they spent equal amount of time caring for psychiatric patients as they did for other patients. However, nurses scored highly (73.2%) in the area of maintaining safe environment for aggressive patients in the department. About one half of the nurses were positive concerning availability of hospital resources and help when needed to deal with patients with mental issues.

Table 4. 13

Self-evaluation on interventions competency

Self-evaluation on interventions competency items	**Score**	**Frequency(n)**	**Percentage**
D1 I can initiate appropriate nursing interventions for common psychiatric issues such as depression, bipolar disorder, and psychosis.	Low	19	46.3
	High	22	53.7
	Total	41	100.0
D2 I can effectively intervene with a patient having hallucinations.	Low	18	43.9
	High	23	56.1
	Total	41	100.0
D3 I am confident that I can recommend use of psychotropic drugs to physicians for appropriate patients.	Low	27	65.9
	High	14	34.1
	Total	41	100.0
D4 I recommend psychotropic drugs to physicians for psychiatric patients.	Low	26	63.4
	High	15	36.6
	Total	41	100.0
D5 I am able to maintain a safe environment for patients in the ward who are aggressive	Low	11	26.8
	High	30	73.2
	Total	41	100.0
D6 I plan for more time to take care of patients with psychiatric issues compared with my other patients.	Low	23	56.1
	High	18	43.9
	Total	41	100.0
D7 I am confident that help is available to me when I need assistance with patients who have comorbid behavioral or psychiatric issues.	Low	18	43.9
	High	23	56.1
	Total	41	100.0
D8 Hospital resources are available to me when I need assistance with behavioral health, psychiatric issues, or substance abuse issues.	Low	20	48.8
	High	21	51.2
	Total	41	100.0
Overall self-evaluation	Low	17	41.5
	High	24	58.5
	Total	**41**	**100.0**

4.7 The association between the independent variables and provision of psychiatric care.

The overall score achieved by combining the scores from all the perceived competencies that is; assessment, therapeutic communication and intervention was deemed as the perceived ability to provide psychiatric care. The p value of .05 was used to describe the significance of the variation in the associations.

According to Table 4.14, most nurses 87.8% (n=36) had strong perceived competency in provision of psychiatric care especially in the area of therapeutic communication. Among the nurses who had perceived competency in psychiatric care, 63.2% (n=12) were female, and 36.8% (n=7) were male. This variation was not significant ($\chi 2$ =0.114 df=1 p=0.735). Among the nurses who felt competent to provide psychiatric care, 73.7% (n=14) were diploma holders in nursing, while those with other qualifications accounted for 26.3% (n=10). The perceived competency did not significantly differ across the nurses' qualifications, LR (2, N=41) = 4.116, P=0.114) neither did it significantly vary from one department to another, LR (4, N=41) = 4.079, P=0.395). However, the study revealed significant variation in perceived competency across the various years of experience LR (4, N=41) =15.985, **P=0.003**). Moreover, the perceived competency in conducting psychiatric assessment had a significant influence on the ability to provide psychiatric care, Fisher's Exact**=0.000**. Likewise, the perceived intervention competency had an influence on the ability to provide care, Fisher's Exact=0.008. However, there was no relationship between perceived communication competency and ability to provide psychiatric care, Fisher's Exact=0.232.

Table 4. 14

Cross tabulation independent variables v Perceived ability to provide psychiatric care

Variable		Self-perception on ability to provide psychiatric care					
		Low		High			
		n	**%**	**n**	**%**	**N**	***Significant at p≤0.05***
Gender	Male	2	40	13	36.1	15	Fisher's **Exact=1.000**
	Female	3	60	23	63.9	26	
	n	**5**	**100**	**36**	**100**	**41**	
Qualifications of nurses	RNs	2	40	29	80.6	31	LR=4.116 df=2 **p=0.114**
	EN	3	60	6	16.7	9	
	BScN	0	0	1	2.8	1	
	n	**5**	**100**	**36**	**100**	**41**	
Department	Mat	1	20	13	36.1	14	LR=4.079 df=4 **p=0.395**
	Fem	0	0	7	19.4	7	
	Male	1	20	6	16.7	7	
	Peds	1	20	6	16.7	7	
	OPD	2	40	4	11.1	6	
	Total	**5**	**100**	**36**	**100**	**41**	
Years of Experience	0-4	0	0	13	36.1	13	LR=15.985 df=4 **p=0.003**
	5-10	0	0	6	16.7	6	
	11-20	4	80	7	19.4	11	
	21-30	0	0	10	27.8	10	
	>30	1	20	0	2.4	1	
	Total	**5**	**100**	**36**	**100**	**41**	
Perceived Psychiatric assessment Competency	Low	4	80	0	0	**36**	Fisher's Exact **p=0.000**
	High	1	20	36	100	**41**	
	n	**5**	**100**	**36**	**100**	**41**	
Perceived Communication competency	Low	1	20	1	2.8	2	Fisher's Exact **p=0.232**
	High	4	80	35	97.2	39	
	n	**5**	**100**	**36**	**100**	**41**	
Perceived intervention competency	Low	5	100	12	33.3	17	Fisher's Exact **p=0.008**
	High	0	0	24	66.7	24	
	n	**5**	**100**	**36**	**100**	**41**	

4.8 Discussion

When demographic variables (namely gender, years of experience, and the nurses' qualification) were cross-tabulated with self-perception on ability to provide psychiatric care, only the nurses' years of experience were significant. In particular, nurses with less than 4 years' experience in nursing practice were more confident of their psychiatric competencies than their senior counterparts. These findings contradict Reed and Fitzgerald (2005)'s assertion that experienced nurses have gained knowledge and skills over time that make them feel more competent in caring for clients with behavioral health need, as compared to their less experienced counterparts. Perhaps younger nurses have the benefit of learning mental health content in the latest revisions of nursing curricula, which may have not been there when their senior colleagues were in training.

The overall score which was achieved by combining the scores from all the perceived competencies studied revealed that nurses were highly confident of their competencies in providing psychiatric care. Combining the scores from all competencies enable one to determine an overall level of achievement and performance which give the practitioner a feeling of advancement in all areas of their work (Eale, et al, 2014). These findings are in tandem with another study of self-evaluation where nurses rated their overall nursing competencies as good and very good (Heydari et al., 2016). The study revealed varying perceptions across the competencies. For instance, most nurses scored highly in communication subscale but low in the intervention subscale. This concurs with the findings of Eales et al. (2014) which revealed that nurses may perceive themselves as inexperienced practitioner in one area and an expert another dimension of practice.

The study revealed that nurses were highly confident of their psychiatric assessment competencies. The confidence may have accrued over time as they routinely assess, diagnose, intervene and communicate to relevant stakeholders on matters touching on the patients (Nadler-Moodie, 2012). Snowden (2012) in the study on the construction of competence in mental health nursing holds that during practice, nurse prescribers construct competence through an interactive process of owning and demonstrating competence. Similarly, experience, adequate practice and training has been shown to shape the nurses' self-confidence to provide care(Sullivan, 2012). However, lack of knowledge on some dimensions of the assessment was evident. This concurs with findings in a qualitative study in another setting (Agar et al., 2012) which revealed nurses' lack knowledge and ability to assess and manage patients with delirium effectively. Other studies have also reported that nurses have difficulties in identifying psychiatric illnesses from medical conditions, because some disorders have unclear symptoms (Kelley et al., 2008; Zieschang, 2005).

Nurses scored highly on perceived ability to communicate effectively in the provision of psychiatric care. One of the reasons for the high levels of the perceived competency in therapeutic communication could be explained by the nature of nursing work and training. Therapeutic communication is among the professional skills frequently highlighted in nursing educational courses and at the work place (Cherry & Jacob, 2016; Miles et al., 2014). However, despite the fact that majority could interpret the patient's implicit communication by listening to verbal cues and observing non-verbal behaviors, they felt inadequate when required to use de-escalation techniques and crisis communication to avert aggressive behaviors.

These findings are in conformity with those of Rutledge (2013), which showed that hospital nurses were more confident in their ability to assess patients than in initiating interventions or acting in situations that may require de-escalation techniques or crisis communication. This study also observed a tendency among most nurses to seek outside help when they encounter psychiatric issues or when patient's behaviors escalate beyond their capabilities. The high score of seeking outside help could be interpreted as avoidance by nurses to attend to psychiatric patients. These findings concur with the report by Reed and Fitzgerald (2005) that says avoidance of psychiatric patient is the greatest influence on nurses' attitudes.

The findings on the intervention competence were mixed. Most respondents stated that they were able to initiate interventions for common psychiatric issues or provide safe environment for clients. On the contrary, the study showed that nurses were not confident in recommending use of psychotropic drugs to physicians for appropriate patients. This is consistent with the findings of a study by Arvidsson (2011) which revealed that general nurses had a feeling of inadequacy in terms of knowledge and skills in assessment and management of mental health problems. This was contrary to the findings of Schleifer (2011) which stated that nurses need to provide care in collaboration with physicians to identify and recommend needed medication. This could only mean that although most nurses perceived that they could identify signs and symptoms of common psychiatric conditions and identify common medications used with psychiatric patients, they were not confident enough to recommend psychotropic medication to physician to use on the patients. In addition, most nurses claimed that they didn't take much time caring for psychiatric patients as they did for other patients. This contradicts past findings in which nurses were more inclined to

spend more time when caring for a patient with mental illnesses, relative to those with other conditions (Kluit et al., 2013).

The study also investigated the influence of various variables on the perceived ability to provide psychiatric care. The nurses' perceived ability to provide psychiatric care did not significantly vary across departments. This contradicts the study by Rutledge, et al. (2012) which revealed that general nurses who worked at the emergency care units and were trained in psychiatric assessment, had strong perceived intervention competency and felt prepared to provide psychiatric care. The study observed significant variation in ability to provide care across the years of experience. Nurses who had worked for less than 11 years were more likely to feel confident of their competency in the provision of psychiatric care. These findings could probably be explained by the fact that, newly graduated nurses could recall the basic psychiatric education which was acquired during their training. This contradict the findings earlier which reported that newly graduated nurses were less confident of their clinical competency(Hengstberger-Sims et al., 2008; Morolong & Chabeli, 2005).

Further, nurses' perceived competency in conducting psychiatric assessment and the perceived intervention competency had an influence on the ability to provide care. However, there was no relationship between perceived communication competency and ability to provide psychiatric care. This contradicts the established practice that emphasizes on effective communication in all aspects of patient care (Cherry & Jacob, 2016; Miles et al., 2014). T6RGG ``````````

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, conclusion and recommendations of the study.

5.2 Summary

The study purpose was to assess nurses' perception of their competencies in the provision of psychiatric care at Loitokitok Sub County Hospital. The specific research objectives that guided this enquiry were: to assess nurses' perception on psychiatric assessment in the provision of psychiatric care; to determine nurses' perception of to apply therapeutic communication in the provision of psychiatric care; to establish nurses' perception of their ability to provide the needed interventions in the psychiatric care; and to determine whether there is an association between nurses' length of professional experience and perception of their competencies to provide psychiatric nursing care. A cross-sectional study, employing census survey of all the 41 eligible nurses working in the hospital was done. A structured questionnaire was used to collect data.

The study registered an impressive response rate of 100%. A third of nurses 34.1% (n=14) were from maternity department. On gender aspect, female nurses were the majority (63.4%, n=26). In overall self-evaluation, nurses were very confident of their ability to assess as well as communicate with patient in the various areas that were presented to them. However, at individual item level most nurses felt they were unable to distinguish between dementia and delirium and slightly more than half could recognize signs and symptoms of drug withdrawal. Most nurses were uncomfortable using crisis communication and de-escalation techniques to distract aggressive

behaviors. Further the inability to de-escalate and communicate during crises, the respondents rarely called for help except when they perceived that the patients' behavior was beyond their ability to handle. On a positive note, the nurses were confident of their ability to initiate appropriate interventions in patients with mental problems such as hallucinations. However, most nurses were uneasy to recommend psychotropic drugs to physician for use in psychiatric patients. Paradoxically, this study did not find any link between ability to communicate and overall ability to provide psychiatric care. Nurses with less than 5 years' experience in nursing practice were more confident of their psychiatric competencies than their senior counterparts.

5.3 Conclusions

The study revealed varying perceptions across the competencies. Most nurses had a strong perceived competency in provision of psychiatric care especially in the area of therapeutic communication. In particular, most nurses were uncomfortable in recognizing withdrawal symptoms, and were unable to properly de-escalate when clients are aggressive. Additionally, the perceived psychiatric care competency did not significantly differ across the nurses' qualifications. However, the study revealed significant variation in perceived competency across the various years of experience. Specifically, the study revealed that nurses who have less than 5 years' working experience had higher confidence levels in providing psychiatric care as compared to their older counterparts. Moreover, the perceived competency in conducting psychiatric assessment had a significant influence on the ability to provide psychiatric care. Especially, the perceived inability among nurses to administer psychotropic could influence care negatively. Likewise, the perceived intervention competency had an influence on the ability to provide care. The study concludes that the perceived competency in the provision of psychiatric care is significantly influenced by the

nurse's working experience, perceived competencies in psychiatric assessment and perceived ability to give the needed interventions at Loitokitok Sub County Hospital.

5.4 Recommendation

1. The Loitokitok Sub-County Hospital nursing administration should have regular assessment of nurses' competencies; forming basis for need based capacity building through such strategies as short-courses and Continuous Development programs (CPDs). Specifically, the hospital should ensure that priority is given to nurses with more than four years, in order to build their confidence levels in psychiatric care.

2. There should be deliberate efforts by individual nurses and the hospital to address challenges that make it difficult to seek assistance, for example when they are not able to de-escalate a patient with aggressive behaviors. Perhaps there needs to channels within the hospital that allow seeking peer-to-peer assistance from colleagues who could be anonymous, online or those who do not have supervisory control over the staff seeking help.

5.5 Areas for further research

This study should be treated as an exploratory enquiry as a result of which the following recommendations on future studies are offered: 1) Investigate actual competencies of nurses' working in a mental hospital; 2) Scrutinize nurses' competencies across all the counties so that there can be a national perspective; 3) Explore reasons why nurses who may be feeling inadequate on certain competencies are unwilling to seek assistance; and 4) A broad based survey on this topic, comprising of larger sample size, should be deployed in collecting quantitative and qualitative data before policy interventions are undertaken.

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Appendix I: Letter of Introduction

Dear Respondent,

I am a postgraduate student at Kenya Methodist University. I am conducting a research project study on "nurses' perception of their competencies in the provision of psychiatric care at Loitokitok Sub-County hospital."

In order to achieve the intended goal, I kindly request you to fill in the attached questionnaire. It is my hope that the findings of this research and subsequent recommendations will help in improving provision of psychiatric care at Loitokitok Sub-County hospital.

The information you will give will be used for the purpose of this research only and will be treated in strict confidentiality.

Thank you in advance for your co-operation.

Yours faithfully,

KEDDY MUCHENE

Appendix II: Consent Form

I understand that the purpose of this study is to explore my perception on competencies in psychiatric care. Further, how I was selected as a participant has been explained to my satisfaction. I have also been given an opportunity to ask questions about the study. I understand that the responses I give will be strictly anonymous, and that my participation will not be disclosed. I have been made aware that my involvement is completely voluntary, and I may withdraw from the study at any time. I am 18 years old or over, and am legally able to provide consent.

Signature of participant. …….. Date……

Appendix III: Questionnaire

Instructions: The purpose of this questionnaire is to obtain information for study purposes only.

- Do not indicate your name or any other identification in the interview schedule.
- Please put a tick (√) in the box next to the right response
- Where no choices are given, please write / fill in the appropriate answer.
- Ensure all the areas are fully completed.

SECTION A: DEMOGRAPHIC INFORMATION

Indicate: -

1. Department you are working in: Maternity [ ] Female Ward [ ] Male Ward [ ] Pediatric Ward [ ] OPD [ ]

2. Gender Male [ ] Female [ ]

3. Professional training of the respondent

Enrolled Nurse [ ] Registered Nurse [ ] BScN Nurse [ ]

4. Years you have worked as a nurse: 0 –4 Years [ ] 5 – 10 Years [ ] 11 - 20Years [ ] 21 – 30 Years [ ]30 yrs. and above [ ]

SECTION B: PSYCHIATRIC ASSESSMENT IN THE PROVISION OF PSYCHIATRIC CAR

Indicate your level of agreement with the following statements relating to Mental Status Assessment competences in the Provision of Psychiatric Care. Use a scale of 1-5, where (1= strongly disagree, 2= disagree, 3= Neutral, 4= Agree and 5= strongly Agree)

Assessment	**1**	**2**	**3**	**4**	**5**
B1. I can assess patients for potential psychiatric problems.					
B2. I identify signs and symptoms of common psychiatric conditions (e.g., depression, schizophrenia, bipolar disorder).					
B3. I can identify common neuroleptic, tranquilizers, and antidepressant medications used with psychiatric patients.					
B4. I am able to assess patients for risk of suicide (suicidality).					
B5. I recognize behaviors that indicate a patient may have alcohol or drug abuse problems.					
B6. I can recognize signs and symptoms of alcohol withdrawal.					
B7. I can recognize signs and symptoms of drug withdrawal.					
B8. I can distinguish between dementia and delirium.					
B9. I can recognize the warning signs in patients whose behavior may escalate to aggression or dangerous behaviors.					

SECTION C: THERAPEUTIC COMMUNICATION COMPETENCES IN THE PROVISION OF PSYCHIATRIC CARE

Indicate your level of agreement with the following statements relating to communication competences in the Provision of Psychiatric Care. Use a scale of 1-5, where (1= strongly disagree, 2= disagree, 3= Neutral, 4= Agree and 5= strongly Agree)

Application of Therapeutic Communication	**1**	**2**	**3**	**4**	**5**
C1. I am able to maintain a therapeutic relationship with most patients on my unit who have psychiatric issues.					
C2. I can recognize and accurately interpret the patient's implicit communication by listening to verbal cues and observing non-verbal behaviors.					
C3. I am able to use de-escalation techniques and crisis communication to avert aggressive behaviors.					
C4. I know when to ask for outside help (e.g., physician, psychiatric nurse, other) for a patient with psychiatric issues or dangerous behaviors.					
C5. I call for outside resources (e.g., physician, psychiatric nurse, other) when I recognize a patient's behaviors are escalating beyond my capabilities.					
C6. I can effectively manage conflicts caused by patients who have mental problems					

SECTION D: INTERVENTION IN PSYCHIATRIC CARE

To what extent do you agree with the following statements on provision of psychiatric Care? Use a scale of 1-5, where (1= strongly disagree, 2= disagree, 3= Neutral, 4= Agree and 5= strongly Agree)

Intervention competency	**1**	**2**	**3**	**4**	**5**
D1. I can initiate appropriate nursing interventions for common psychiatric issues such as depression, bipolar disorder, and psychosis.					
D2. I can effectively intervene with a patient having hallucinations.					
D3. I am confident that I can recommend use of psychotropic drugs to physicians for appropriate patients.					
D4. I recommend psychotropic drugs to physicians for psychiatric patients.					
D5. I am able to maintain a safe environment for patients in the ward who are aggressive					
D6. I plan for more time to take care of patients with psychiatric issues compared with my other patients.					
D7. I am confident that help is available to me when I need assistance with patients who have comorbid behavioral or psychiatric issues.					
D8. Hospital resources are available to me when I need assistance with behavioral health, psychiatric issues, or substance abuse issues.					

Appendix IV: Approval by KeMU Scientific Ethics and Review Committee

KENYA METHODIST UNIVERSITY
P. O. BOX 267 MERU - 60200, KENYA
TEL: 254-064-30301/31229/30367/31171
FAX: 254-64-30162
EMAIL: INFO@KEMU.AC.KE

May 28, 2020 KeMU/SERC/MSN/14/2020

Keddy Wanjiru Muchene
Kenya Methodist University

Dear Keddy,

SUBJECT: ***ASSESSMENT OF NURSES' PERCEPTION OF THEIR COMPETENCIES IN THE PROVISION OF PSYCHIATRIC CARE AT LOITOKITOK SUB-COUNTY HOSPITAL***

This is to inform you that Kenya Methodist University Scientific Ethics and Review Committee has reviewed and approved your above research proposal. Your application approval number is KeMU/SERC/MSN/14/2020. The approval period is 28th May 2020 – 28th May 2021.

This approval is subject to compliance with the following requirements

I. Only approved documents including (informed consents, study instruments, MTA) will be used.

II. All changes including (amendments, deviations, and violations) are submitted for review and approval by Kenya Methodist University Scientific Ethics and Review committee.

III. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to KeMU SERC within 72 hours of notification.

IV. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KeMU SERC within 72 hours.

V. Clearance for export of biological specimens must be obtained from relevant institutions.

VI. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal

VII. Submission of an executive summary report within 90 days upon completion of the study to KeMU SERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,
KEMU SERC
20 MAY 2020
Dr. A. WANGACHI
P.O. Box 267 - 60200 MERU
Chair, SERC

Appendix V: NACOSTI Research License

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 532402

Date of Issue: 11/June/2020

RESEARCH LICENSE

This is to Certify that Ms.. Keddy Wanjiru Muchene of Kenya Methodist University, has been licensed to conduct research in Kajiado on the topic: ASSESSMENT OF NURSES' PERCEPTION OF THEIR COMPETENCIES IN THE PROVISION OF PSYCHIATRIC CARE AT LOITOKITOK SUB COUNTY HOSPITAL.. for the period ending : 11/June/2021.

License No: NACOSTI/P/20/5211

532402

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

Appendix VI: Loitoktok HospitalApproval to collect data

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF KAJIADO

moh.loitokitok@gmail.com.
When replying please quote ref & date.
Ref: LSCH/MOH/2/19

SUB COUNTY MEDICAL OFFICER,
COUNTY DEPARTMENT OF HEALTH,
P.O. BOX 28-00209,
LOITOKITOK.

11th June 2020.

TO
THE MEDICAL SUPERINTENDENT,
LOITOKITOK SUB COUNTY HOSPITAL,
P.O. BOX 28,
LOITOKITOK.

RE: KEDDY WANJIRU MUCHENE - LICENSE NO. NACOSTI/P/20/5211.

The above named student Keddy Wanjiru Muchene of Kenya Methodist University – Application identification No. 532402 has been licensed by NACOSTI to conduct research in Kajiado on the topic Assessment of Nurses perception of their Competencies in the provision of psychiatric care at Loitokitok Sub County Hospital for the period ending 11th June 2021.

This is to certify that she has been granted permission to conduct the said study in the hospital for the specified period.

Any assistance accorded to her will be highly appreciated.

MEDICAL OFFICER OF HEALTH
LOITOKITOK DISTRICT
DATE: 11/6/2020

WILSON CHESUM,
SUB COUNTY MEDICAL OFFICER OF HEALTH,
KAJIADO SOUTH.